

Solano County Sheriff – Coroners Office
Next of Kin Notification Policy
2002-2003 Grand Jury Report

I. Reason for Investigation

The Solano County Grand Jury investigated a citizen's complaint alleging the Coroner failed to make a timely death notification. The accident occurred at 1600 hour but complainant was not notified until 2230 hours.

II. Procedure

The Grand Jury:

- Interviewed the Chief Deputy County Coroner
- Interviewed the Complainant
- Obtained and reviewed the Coroner's "Next of Kin Notification Policy"
- Obtained and reviewed the Deceased Coroner's Death Reports
- Reviewed the California Highway Patrol's (CHP) Accident Report.

III. Background

1. The Complainant's spouse and son were killed in a highway accident at 1600 hours, as shown in the CHP Report and 1435 hours, as shown in the Coroner's Report. The Complainant alleges there was ample evidence at the accident site to identify the victims such as the auto registration and that some of the emergency personnel knew this family. The Coroner says no identification was found at the site.

2. The Sheriff's Department General Order No. 7009 – Notification of Next of Kin states:

"Death notifications shall be made as soon as possible after identification of the decedent. If notification is delayed, the delay and reasons for that delay shall be documented in the Coroner's Report."

It further states that "Notification shall be made in person whenever possible."

3. The Grand Jury reviewed the Coroner's Report which states the Coroner, while still at the site of the accident, received a call to report to another fatal accident in Benicia. The Coroner and its transportation service van went directly to the site of the second accident prior to delivering bodies to the morgue. The report does not clearly show times of events. Some of the victim's personal belongings from the accident scene were returned to the family in a garbage bag.

IV. Findings and Recommendations

Each finding is referenced to the background paragraph number

Finding # 1 - The Solano County Coroner did not follow its own Death Notification Policy. The notification was delayed because the Coroner did not deliver the bodies to the morgue before reporting to the second accident. Bodies from both accidents were delivered to the morgue at 2145 hours by the Coroner's vehicles and two contract transporter vehicles. (2) (3)

Recommendation # 1 - In instances of multiple accidents such as this, the contract transporter delivers bodies to the morgue. Then the on-site Coroner, en route to the second accident, calls and apprises the supervisor of the situation. The supervisor should then take on the responsibility of identification and notification.

Finding # 2 - Returning victim's belongings to family in a garbage bag conveyed the image that belongings were perceived by the Coroner as trash. (4)

Recommendation # 2 - Belongings should be returned to families in a box or neatly wrapped in paper.

Finding # 3 - The Grand Jury found the Coroner's Report to be incomplete, with errors and not consistent with the CHP Report or the Transporter statements. (3)

Recommendation # 3 - The Coroner's Report should detail times of events accurately to ensure completeness and correctness in its reports. All reports and revisions should be dated and timelines noted.

V. Comments

The Grand Jury recognizes that multiple fatality accidents are not the norm for the Coroner to handle. However, the handling of bodies and notification in instances such as this should be addressed in its General Order No. 7009.

Affected Agencies

- Solano County Board of Supervisors
 - Solano County Sheriff – Coroner
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